BlueCross BlueShield of Vermont
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Vermont Freedom Plan - Preferred Provider Organization (PPO)

$200 / $400 Individual / Family Deductible, 20% Coinsurance, $10 PCP and Specialist Office Visit Co-payment, $600 / $1,200 Individual / Family Out-of-Pocket Limit
Prescription Drugs - $0 Deductible, $10 Generic, $15 Preferred Brand-Name, or $15 Non-Preferred Brand-Name Co-payments

Created For: City of Burlington

BENEFIT HIGHLIGHTS	PREFERRED PROVIDERS	NON-PREFERRED PROVIDERS
Calendar Year Deductible	$200 Individual $400 Family	$500 Individual $1,000 Family
Coinsurance	Plan pays 80% of our allowed price after you meet your deductible. You pay 20% of our allowed price up to your out-of-pocket limit.	Plan pays 70% of our allowed price after you meet your deductible. You pay 30% of our allowed price up to your out-of-pocket limit.
Calendar Year Out-of-Pocket Limit	$600 Individual $1,200 Family When you meet your out-of-pocket limit, we pay 100% of our allowed price.	$1,500 Individual $2,000 Family When you meet your out-of-pocket limit, we pay 100% of our allowed price.
Lifetime Maximum	$2,000,000 per member per lifetime	$2,000,000 per member per lifetime
Transplant Services Benefit Maximum	$2,000,000 per member per lifetime	$2,000,000 per member per lifetime

	PREFERRED PROVIDERS		NON-PREFERRED PROVIDERS	
OUTPATIENT CARE	**YOU PAY**	**PLAN PAYS**	**YOU PAY**	**PLAN PAYS**
Routine Physical Examinations *Includes annual OB-GYN exam, preventive PAP test, well-child care, screening mammograms*	No member cost	100% of our allowed price	Deductible, then 30% of our allowed price	70% of our allowed price after deductible
Screening Mammography *Excludes diagnostic services*	No member cost	100% of our allowed price	No member cost	100% of our allowed price
Colorectal Screening *Excludes diagnostic services; includes screening PSA tests*	No member cost	100% of our allowed price	Deductible, then 30% of our allowed price	70% of our allowed price after deductible
Primary Care and Specialist Physician Office Visits	$10 co-payment	100% of our allowed price after co-payment	Deductible, then 30% of our allowed price	70% of our allowed price after deductible
Outpatient Mental Health and Substance Abuse Office Visits	$10 co-payment	100% of our allowed price after co-payment	Deductible, then 30% of our allowed price	70% of our allowed price after deductible
Outpatient Mental Health and Substance Abuse Services	Deductible, then 20% of our allowed price	80% of our allowed price after deductible	Deductible, then 30% of our allowed price	70% of our allowed price after deductible
Maternity Office Visits	Deductible, then 20% of our allowed price	80% of our allowed price after deductible	Deductible, then 30% of our allowed price	70% of our allowed price after deductible
Nutritional Counseling *Up to three visits; visits for treatment of diabetes do not count toward the three-visit limit*	$10 co-payment	100% of our allowed price after co-payment	100% of charges	Not a covered benefit

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OUTPATIENT CARE	YOU PAY	PLAN PAYS	YOU PAY	PLAN PAYS
Chiropractic Visits *Prior approval required after 12 visits*	$10 co-payment	100% of our allowed price after co-payment	100% of charges	Not a covered benefit
Emergency Room Physician	$10 co-payment	100% of our allowed priced after co-payment	Deductible, then 30% of our allowed price	70% of our allowed after deductible
Emergency Room *Covered when your condition meets criteria for necessary emergency care*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible	Deductible, then 30% of our allowed price	70% of our allowed price after deductible
Emergency Mental Health and Substance Abuse Services *Covered when your condition meets criteria for necessary emergency care Includes facility and physician services.*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible	Deductible, then 30% of our allowed price	70% of our allowed price after deductible
Diagnostic Services *Includes laboratory and x-ray*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible	Deductible, then 30% of our allowed price	70% of our allowed price after deductible
Outpatient Surgery *Prior approval may be required*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible	Deductible, then 30% of our allowed price	70% of our allowed price after deductible
Outpatient Physical, Occupational, and Speech Therapy *Up to 30 visits combined per calendar year*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible	Deductible, then 30% of our allowed price	70% of our allowed price after deductible
INPATIENT CARE	**YOU PAY**	**PLAN PAYS**	**YOU PAY**	**PLAN PAYS**
Inpatient Care, General Hospital *Requires precertification*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible	Deductible, then 30% of our allowed price	70% of our allowed price after deductible
Inpatient Care, Mental Health or Substance Abuse	Deductible, then 20% of our allowed price	80% of our allowed price after deductible	Deductible, then 30% of our allowed price	70% of our allowed price after deductible
HOME CARE AND REHABILITATION SERVICES	**YOU PAY**	**PLAN PAYS**	**YOU PAY**	**PLAN PAYS**
Inpatient Skilled Nursing	Deductible, then 20% of our allowed price	80% of our allowed price after deductible	100% of charges	Not a covered benefit
Inpatient Rehabilitation *Requires prior approval*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible	100% of charges	Not a covered benefit
Home Health and Hospice Care Services	Deductible, then 20% of our allowed price	80% of our allowed price after deductible	Deductible, then 30% of our allowed price	70% of our allowed price after deductible
Cardiac Rehabilitation *Up to 36 sessions per acute cardiac event; requires prior approval*	$10 co-payment	100% of our allowed price after co-payment	100% of charges	Not a covered benefit
Private Duty Nursing *Up to $2,000 per member per calendar year; requires prior approval*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible	Deductible, then 30% of our allowed price	70% of our allowed price after deductible

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OTHER SERVICES	YOU PAY	PLAN PAYS	YOU PAY	PLAN PAYS
Ambulance *Includes emergency and routine transport. Prior approval required for non-emergency transport*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible	Deductible, then 20% of our allowed price	80% of our allowed price after deductible
Medical Equipment and Supplies *Prior approval may be required*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible	Deductible, then 30% of our allowed price	70% of our allowed price after deductible

PRESCRIPTION DRUGS	YOU PAY	PLAN PAYS	YOU PAY	PLAN PAYS
Retail Pharmacy Program *Up to a 30-day supply. Prior approval may be required*	$10 Generic co-payment	100% after co-payment	100% of charges	Not a covered benefit
	$15 brand-name co-payment If a drug is only available as a Brand-Name Drug, the member will be charged the Generic co-pay.	100% after co-payment	100% of charges	Not a covered benefit
Home Delivery Pharmacy Program *Up to a 90-day supply. Prior approval may be required*	$20 generic co-payment	100% after co-payment	100% of charges	Not a covered benefit
	$30 brand-name co-payment If a drug is only available as a Brand-Name Drug, the member will be charged the Generic co-pay.	100% after co-payment	100% of charges	Not a covered benefit

This document summarizes the benefits of your health care plan per calendar year. Your subscriber contract defines the complete terms and conditions of your benefits in detail. Should any questions arise concerning your benefits, your subscriber contract governs.

Benefits paid by your health plan for services rendered by Preferred Providers and Non-Preferred Providers are combined and applied to a common lifetime Transplant Services Benefit Maximum dollar amount.

Diabetic medications are covered at 100%.
Deductible will accumulate January 1 through December 31 with no carry-over to the following year.
Benefit Enhancement Rider.

Federal Mental Health Parity applies; Mental Health and Substance Abuse benefits are subject to change pending final interpretation and requirements of the Federal Mental Health Parity mandate

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